Continuing Medical & Dental Coverage Under Provisions of the Federal COBRA Law for Retirees and Their Dependents

Important note: The federal COBRA (Consolidated Omnibus Budget Reconciliation Act) law gives you and your covered dependents the right to continue employer-provided group health coverage on a self-paid basis for up to 18 months (and in some cases up to 36 months) after you would otherwise lose eligibility. This instruction sheet (a) describes your rights under the federal COBRA law, (b) specifies what you must do to maintain your coverage, and (c) lists the current premium rates for continuation of coverage.

Your right to COBRA continuation begins when a "qualifying event" occurs. This is an occurrence that causes you or a covered dependent to become ineligible for Public Employees Benefits Board (PEBB)-sponsored coverage. Qualifying events are described in more detail on the next page. To exercise your COBRA right, you or your dependents must submit an enrollment form within 60 days following the date of the qualifying event or the date on which you receive notice from the Health Care Authority (HCA), whichever is later. **Premiums must be paid retroactive to the first day of the month following the qualifying event.** The law allows you and/or your dependents to continue medical coverage only, or medical and dental coverage together, but not dental coverage only. You and each of your enrolled family members are entitled to make a separate decision about whether to continue coverage.

You and your dependents are not eligible for COBRA continuation if you become covered under another group health plan after the date of the COBRA election, unless that plan contains a pre-existing condition exclusion or limitation that applies to the person covered. If such a limitation exists, you may be eligible for COBRA coverage. When the pre-existing condition waiting period ends in the other plan covering you, your COBRA eligibility ends.

Your Responsibility for Reporting Qualifying Events

You and your dependents also have a responsibility under COBRA to provide notice to the HCA within 60 days after a qualifying event occurs.

The HCA's Responsibility to You Under COBRA

The COBRA law requires the HCA or your retirement system to notify you and your dependents of your COBRA rights within 14 days of receiving your notification of a qualifying event. You may then exercise your COBRA rights by completing a COBRA enrollment form and sending it to the HCA within 60 days of the qualifying event or the date on which you receive notice of your rights, whichever is later. Along with the enrollment form, please send in the required premium. This will prevent delays in enrollment and/or claims processing. However, by law, you have up to 45 days from your COBRA enrollment date to pay your premiums.

"Qualifying Events" Under the COBRA Law

A retiree and his or her covered dependents are entitled to continue PEBB-sponsored health care coverage for up to 18 months (and in some cases longer) on a self-paid basis if either of these events occurs:

- The retiree ceases to qualify for disability retirement.
- The retiree retired from an employer group that began participation in PEBB-sponsored benefits after September 15, 1991, as defined in Washington Administrative Code (WAC) 182-12-111(2), and the employer group terminates participation in the PEBB program.

The enrolled dependents of a retiree are entitled to continue coverage for up to 36 months on a self-paid basis when any of these events occurs:

- The retiree becomes divorced.
- A child ceases to be a dependent child of the retiree under the plan's eligibility rules.

How to Arrange Continuation of Coverage Under COBRA

By law, you have 60 days in which to enroll under COBRA, and then 45 days from the date of enrollment to make the first premium payment. **However, premiums must be paid retroactive to the first day of the month following the qualifying event.** To avoid a delay in obtaining benefits and the inconvenience of having to pay several months' premiums at the same time, it is to your advantage to send in the COBRA form and first month's payment immediately after you decide to continue coverage.

1. To continue group insurance coverage under COBRA, you or your eligible dependents must complete a new COBRA form that lists all persons to be covered under the terms of continuation. You are not allowed to change medical or dental plans at the time you continue your benefits under COBRA. You will be allowed to change health plans only during an open enrollment period or when you move out of your plan's service area.

   If an eligible dependent of a retiree elects to enroll in COBRA coverage after a qualifying event, he or she should complete the COBRA form, **making sure that the retiree's name and social security number appear at the top left corner of the form.**

2. If you or your dependents are eligible and want to continue your group coverage under COBRA, send the completed form and a check for the first month's premium (based on the current COBRA rate schedule in this document) to:

   Washington State Health Care Authority
   P.O. Box 42695
   Olympia, WA 98504-2695

   Make check payable to the Washington State Treasurer.

3. After the first payment is made, premiums will be due on the 15th of each month of coverage, and will be past due on the 23rd. Late premium payment or return of a check for insufficient funds will be cause for cancellation of coverage without notification, effective on the last day of the month in which the premium was paid in full.
4. If any changes in coverage need to be made while premiums are self-paid, contact the Health Care Authority.
5. If you wish to terminate your coverage under COBRA, you must submit a written request. **Termination will be effective the first day of the month following receipt of the termination notice.**

When COBRA Continuation Ends

The right to continue coverage under COBRA ends when any of the following occurs:

1. The COBRA continuation period ends.
2. COBRA premiums are not paid in full or in a timely manner.
3. The plan terminates.
4. You or an enrolled dependent become covered under another group health plan after the date of the COBRA election. However, if the other plan contains a pre-existing condition exclusion or limitation that applies to the person covered, you may continue your COBRA coverage until the pre-existing condition waiting period ends in the other plan.
5. You send a written request to terminate coverage.

Converting to an Individual Medical Policy

When your COBRA continuation period expires, you and your enrolled dependents are eligible for a conversion plan offered by your current health plan without providing evidence of good health unless covered under another group plan or Medicare. Application for conversion coverage must be made within 31 days from the date PEBB coverage ends. Uniform Medical Plan (UMP) enrollees must apply through the HCA. Enrollees in other PEBB-sponsored health care plans must apply directly to their insurance plan.

If you and/or your dependents choose not to enroll in a conversion plan, your COBRA group coverage will end when the COBRA continuation period expires.

The HCA's staff of benefits specialists is available to answer your questions about HCA and PEBB policies, plan eligibility and enrollment, COBRA continuation, or conversion of coverage.

Where to Go for Assistance

Contact the HCA:

Olympia and vicinity 360-412-4200
Outside Olympia 1-800-200-1004

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm data before making decisions.

Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

To obtain this publication in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Public Employees Benefits Board (PEBB)

2003 COBRA Continuation of Medical and Dental Coverage for Retiree and Retiree Dependents

- All covered family members must be included on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Make checks payable to the State Treasurer.

For dependents of retirees ONLY	Retiree name	
	Retiree social security number	Date employer coverage ended (mm/dd/yyyy)

SECTION 1: Subscriber Information

Social security number	Sex ❑ M ❑ F	Last name	First name	Middle initial

Address | Apt./unit number

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan for code.** ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

Are you disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No

Are you covered by another group medical or dental plan? ❑ Yes ❑ No

If so, does that plan have a pre-existing condition clause, limitation, or exclusion? ❑ Yes ❑ No
If yes, submit a copy of the plan with this form.

Are you or your spouse or same-sex domestic partner enrolled in both Parts A & B of Medicare?
Subscriber: ❑ Yes ❑ No
Spouse or same-sex domestic partner: ❑ Yes ❑ No

Are you or your spouse or same-sex domestic partner on Medicare disability? ❑ Yes ❑ No

Note: *If you or your dependents are Medicare eligible, you must be enrolled in Medicare Parts A and B. If you haven't sent in a copy of your Medicare card(s), please send a copy of it along with this form.*

SECTION 2: Family Member Information

List only family members you wish to cover.

Relationship to subscriber ❑ **Spouse** OR ❑ **Same-sex domestic partner**	Social security number	Physician or clinic code (contact plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

Other Family Members (such as child, grandchild, etc.) ***Use additional forms for more members***

A	**Relationship to subscriber**	❑ Disabled? ❑ Student? *(Check only if age 20 or older.)*	Sex ❑ M ❑ F
Social security number		Physician or clinic code (contact your plan for code)	

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

SECTION 2: Family Member Information (continued)

B **Relationship to subscriber** | ❑ Disabled? ❑ Student? *(Check only if age 20 or older.)* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

SECTION 3: Changes

(Check all that apply.)

Subscriber changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

I wish to cancel **medical** coverage. ❑ Yes ❑ No

I wish to cancel **dental** coverage. ❑ Yes ❑ No

Change in family status:

❑ **Adding a spouse or same-sex domestic partner.** You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov.

❑ **Adding family member A**

❑ **Adding family member B**

❑ **Widowed** Date (mm/dd/yyyy)_____

❑ **Removing a spouse or same-sex domestic partner from coverage.** Please provide his/her new address, date of event, and reason:

Address _____

_____

Date (mm/dd/yyyy) _____

Reason _____

❑ **Removing other family members from coverage**

Name _____

Date (mm/dd/yyyy) _____

SECTION 4: Medical Plan Selection

(Check only one.)

❑ Group Health Cooperative of Puget Sound

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ Medicare Supplement Plan E, administered by Premera Blue Cross

❑ Medicare Supplement Plan J, administered by Premera Blue Cross

❑ PacifiCare of Washington, Inc.*

❑ Premera Blue Cross

❑ RegenceCare*

❑ Uniform Medical Plan

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code.*

SECTION 5: Dental Plan Selection

(Check only one.)

Preferred Provider Organization

(may receive services *from any provider*):

❑ Uniform Dental Plan (Group #3000)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Columbia Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 6: Signature (Required)

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I certify that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all previous forms I have submitted for Public Employees Benefits Board medical/dental coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____

Subscriber's signature Date

Please sign and date this form.

Return form and check to:
Washington State Health Care Authority,
P.O. Box 42684, Olympia, WA 98504-2684

Washington State Health Care Authority
Public Employees Benefits Board

Visit our Web site at www.pebb.hca.wa.gov.

For Agency Use Only	Retiree name	SSN	❑ 18-month (loss of disabled retiree eligibility) ❑ 36-month (loss of dependent eligibility)